

7821

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
37 TOWN <u>CHESTERTOWN</u>		4 HRS		TOWN <u>KENNEDYVILLE</u>		RURAL <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
72 <u>KENT & QUEEN ANN'S HOSPITAL</u>				<u>NEAR LOCUST GROVE</u>			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		<u>IVY</u>		<u>ANNE</u>		<u>DAY</u>	
4. DATE (Month) (Day) (Year)		OF DEATH:		<u>AUG. 10,</u>		<u>19 55</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>FEMALE</u>		<u>COLORED</u>		<u>SINGLE</u>		<u>SEPT. ? 1954.</u>	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
yrs. <u>11</u>		<u>?</u>		<u>?</u>		<u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>NONE</u>		<u>NONE</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>ISIAH DAY</u>				<u>NELLIE MARSHALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NONE</u>		<u>ISIAH DAY, KENNEDYVILLE, RFD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>571.0</u>							
IMMEDIATE CAUSE (A) <u>Acute enteritis (unknown)</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/9</u> , 19 <u>55</u> , to <u>8/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>55</u> , and that death occurred at <u>4:10 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. R. Jones</u>		M. D. <u>Kennedyville, Md</u>		DATE SIGNED <u>8/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>AUG 11, 1955</u>		<u>MT. ZION CEMETERY</u>		<u>STILL POND, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/10/55</u>		REGISTRAR'S SIGNATURE <u>E. R. Jones</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>B. R. FELLOWS</u>		<u>STILL POND, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

acute ENTERITIS
causative organism
unknown

BUREAU V. S.

AUG 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07830

7325 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Items 2,13,14 FilmG185 8-22-55 et

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Kent MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Near Rock Hall		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Airplane crash in Chesapeake Bay		STREET ADDRESS (If rural, give location) 922 Belgian Avenue	
3. NAME OF DECEASED (Type or Print) Charles Hiram		4. DATE OF DEATH Aug. 7, 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 8/24/1932
9. AGE last birthday 22 yrs.		10. UNDER 1 year Months Days	11. UNDER 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Camden, N. J.
13. FATHER'S NAME William Owens		14. MOTHER'S MAIDEN NAME Catherine Bosch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 562-40-5687	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause 863X Injuries, multiple, severe		
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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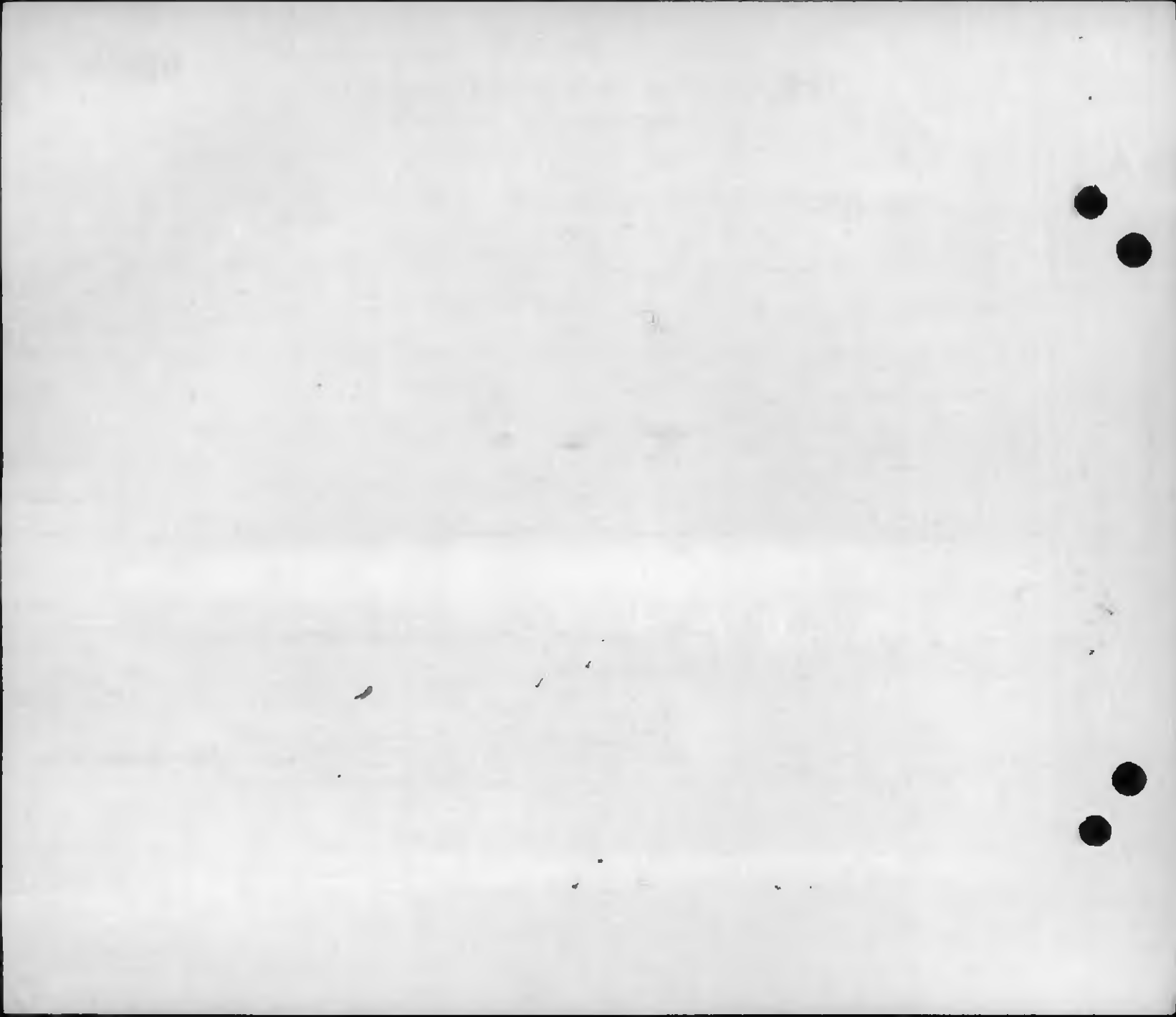
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE OF INJURY Office, home, etc. Rock Hall, Md.	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) Aug 7 1955 3:00 m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Airplane crashed on Chesapeake Bay with no understanding near Rock Hall, Md.		

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		SIGNATURE M. D. Chestertown, Md.	DATE SIGNED 8/10/55
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23. BURIAL, CREMATION REMOVAL (Specify) Cremation	DATE THEREOF 8-13-55	NAME OF CEMETERY OR CREMATORY Brunson	LOCATION (City, town, or county) Baltimore	(State) Md.
DATE REC'D BY LOCAL REG. 8-15-55	REGISTRAR'S SIGNATURE J. H. Hedrick	24. FUNERAL DIRECTOR L. J. Ruch		ADDRESS 5305 7th Avenue

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7822

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Keet</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN <u>Chestertown</u>		16 days		TOWN <u>Chestertown</u>		17X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
12 <u>Keet & Queen Anne's Hwy</u>				<u>Road top Road</u> ✓			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>B. Walter</u>		(Middle)		(Last) <u>Ferguson</u>		(Date) (Month) (Day) (Year)	
(Type or Print)						<u>August 28 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept 21 1885</u>	<u>70 yrs</u>	Months	Days	Hours
					<u>11</u>	<u>24</u>	<u>04</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Retired teacher</u>				<u>Farming</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>New Jersey</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Ferguson</u>				<u>Clara Champion</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Unknown</u>				<u>No</u>		<u>Hospital records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>		<u>48 hrs</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
<u>8-19-55</u>	<u>Enlarged prostate</u>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12, 1954, to 8-28, 1955, that I last saw the deceased alive on 8-28, 1955, and that death occurred at 6:30 p M, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Aug. 31, 1955</u>	<u>Springfield Cem.</u>	<u>Springfield Queens Co. New York</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
<u>Aug. 29-1955</u>		<u>Clara L. Barnes</u>		<u>J. Willis Wells - Chestertown, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 31 1935

RECEIVED

7826

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY KENT		MARYLAND		STATE MD.		COUNTY KENT	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN WORTON R.F.D.		20 YRS.		TOWN WORTON R.F.D.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) HELEN (Middle) E. (Last) HYNISON				OF DEATH: AUG. 20 19 55.			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	NEGRO	MARRIED	JAN. 12, 1898	57 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		HOME		MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
ANDREW BUTLER				CAROLINE SCOTT			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
No		NONE		GILBERT HYNISON WORTON, R.F.D.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE						3 weeks	
(A) Renal failure							
DUE TO							
ANTECEDENT CAUSE (S)						2 + years	
(B) Hypertensive Cardiovascular disease							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						18 months -	
Cerebrovascular accident							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May , 19 55 , to August , 19 55 , that I last saw the deceased alive on Aug. 12 , 19 55 , and that death occurred at 2:45 AM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Florena Deringer Jones		Worton, Md		8/20/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		AUG. 23, 1955		ST. GEORGE'S CENTY		WORTON R.F.D. MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Shelby E. Kennard Jones		B. R. FELLOWS		STILL POND, MD			

MARGIN RESERVED FOR BINDING

BUREAU V. 3

AUG 26 1955

RECEIVED

Reg. Dist. No. 502

CERTIFICATE OF DEATH

Reg. Dist. No. 502

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>An.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>37TOWN Chestertown</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>	<u>17X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Kent + Queen Annes Hospital</u>		STREET ADDRESS (If rural give location) <u>P.R.#1</u>	<u>J</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Baby Boy Kennedy</u>		OF DEATH: <u>August 17 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>August 17, 1955</u>
9. AGE last birthday		IF UNDER 1 YEAR Months Days	
<u>6 yrs.</u>		<u>6 45</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Walter Elzie Kennedy</u>		14. MOTHER'S MAIDEN NAME: <u>AREZILIA Virginia Massey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mother - Millington, Md. ITR#</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>762.0</u>		<u>6 hrs 45'</u>	
IMMEDIATE CAUSE		(A) <u>Unknown</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) <u>Was born spent time only after a short labor and with use of minimal amounts of N.O. Did not breathe well at anytime & became extremely</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		(C) <u>asphyxiated when out of oxygen. There was probably some atelectasis. Had several convulsions clinically & perium & asphyxiation</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/17 55</u> , to <u>8/17 55</u> , that I last saw the deceased alive on <u>8/19 55</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>md 8/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Buried</u>		<u>Aug 18, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>mt Pleasant Cem.</u>		<u>Pondtown Crumpton md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>Aug 18-1955</u>		<u>Edward Yellow Millington md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 22 1965

RECEIVED

7324

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>KENT.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>KENT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37</u> TOWN <u>CHESTERTOWN</u>		LENGTH OF STAY (In this place) <u>22</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHESTERTOWN</u> <u>37</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72</u> <u>KENTY QUEEN ANNE'S</u> <u>1752</u>				STREET ADDRESS (If rural give location) <u>102 LYNCHBURG ST.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>GEORGE</u> (Middle) <u>EDWARD</u> (Last) <u>LINDSEY</u>				OF DEATH: <u>8</u> <u>28</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>JUL 5 1909</u>	
				9. AGE last birthday: <u>46</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Cannery</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>George Lindsey</u>				14. MOTHER'S MAIDEN NAME: <u>Blanche Johnson.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>UNK.</u>				16. SOCIAL SECURITY NO.: <u>220-16-9524</u>		17. INFORMANT & ADDRESS: <u>HOSP. CHART.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>INTESTINAL OBSTRUCTION.</u>		<u>2 wks.</u>
ANTECEDENT CAUSE (B) <u>METASTATIC CARCINOMA OF RECTUM,</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>to Mesentery, Liver, Omentum & Small intestine.</u>		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>8. 12. 55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Obstruction of Ileum due to metastatic carcinoma</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8. 6. 1955, to 8. 28. 1955, that I last saw the deceased alive on 8. 25. 1955, and that death occurred at 7:30 M, from the causes and on the date stated above.

SIGNATURE William T. Kemp ADDRESS CHESTERTOWN, Md. DATE SIGNED 8. 29. 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/1/55</u>	<u>Rich Neck (col.) Cem.</u>	<u>near Church Hill</u>
			<u>Queen Anne Co. Md.</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>Aug. 29-1955</u>	<u>Clara L. Barnes.</u>	<u>J. Willis Wells - Chestertown, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 21

BUREAU V. S.

7327

CERTIFICATE OF DEATH

Reg. Dist. No. 201.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY KENT	MARYLAND	STATE MD.	COUNTY KENT
CITY (If outside corporate limits, write RURAL, OR and give nearest town) STILL POND	LENGTH OF STAY (in this place) LIFETIME	CITY (If outside corporate limits, write RURAL and give nearest town) STILL POND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS —		STREET ADDRESS (If rural give location) —	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
MAURICE PEAKER		AUG. 17, 1955	
5. SEX: MALE	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: SEPT. 15, 1886
9. AGE last birthday: 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: LEWIN PEAKER		14. MOTHER'S MAIDEN NAME: ROSIE GARRISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO		16. SOCIAL SECURITY NO.: NONE	
17. INFORMANT & ADDRESS: MARTHA PEAKER STILL POND, MD.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) hypertension			
ANTECEDENT CAUSE (B) Cerebral Hemorrhage			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: —			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from June 15, 1955 to Aug. 17, 1955 , that I last saw the deceased alive on Aug 14, 1955 , and that death occurred at 140A M, from the causes and on the date stated above.			
SIGNATURE E. Kestel		ADDRESS Rock Hall DATE SIGNED 8/18/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF AUG. 20, '55	
NAME OF CEMETERY OR CREMATORY FOUNTAIN CEMETERY		LOCATION (City, town, or county) (State) WORTON, RURAL, MD.	
DATE REC'D BY LOCAL REGISTRAR 8/18/55		REGISTRAR'S SIGNATURE E. J. J. Jones	
24. FUNERAL DIRECTOR B. R. FELLOWS		ADDRESS STILL POND, MD.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Kester P. L. Hall

1 40 a.m.

BUREAU V. 3

AUG 10 1955



7828

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07836

Reg. Dist. No. 208

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>near Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
TOWN <u>near Rock Hall</u>		TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Airplane crash in Chesapeake Bay</u>		STREET ADDRESS (If rural, give location) <u>4804 Wellington Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ann Rodgers</u>		4. DATE OF DEATH <u>8-7-55</u> 19	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>Feb. 17, 1935</u> 20 yrs.	
9. AGE last birthday <u>20</u> yrs.		10. AGE last birthday <u>20</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wm. L. Rodgers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
863X Immediate cause (a) <u>Injuries, multiple, severe</u>		<u>none</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE OF INJURY <u>Chesapeake Bay near Rock Hall, Kent, Md.</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug 7, 1955 5:30 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
		HOW DID INJURY OCCUR? <u>airplane crashed in water during thunderstorm</u>			

22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		SIGNATURE <u>Robert W. Jones</u>	DATE SIGNED <u>8/10/55</u>
		ADDRESS <u>Chesapeake Bay</u>	

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8-13-55</u>	NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>	LOCATION (City, town, or county) <u>Alexandria, Virginia</u>	(State)
DATE REC'D BY LOCAL REG. <u>8/13/55</u>		REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u>		24. FUNERAL DIRECTOR <u>Robert W. Jones</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

AUG 18 1955

BUREAU V. S.

7329

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>KENT</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>BETTERTON</u>	<u>1 yr</u>	<u>BETTERTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
<u>Ruth Victoria Wilson</u>			<u>Aug 22 19 53</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. UNDER 1 YEAR
<u>F</u>	<u>NEGRO</u>	<u>M</u>	<u>Feb 12, 1901</u>	<u>54</u> yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>COOK</u>		<u>HOTEL</u>		<u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME:		
<u>45</u>			<u>John S. Wilmore</u>		

14. MOTHER'S MAIDEN NAME:		15. INFORMANT & ADDRESS:	
<u>KATIE BROOKS</u>		<u>VIVIAN HENDERSON, BETTERTON, MD</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
<u>no</u>		<u>215-12-6756</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
434.3 IMMEDIATE CAUSE		15 min -	
(A) <u>acute pulmonary edema</u>			
DUE TO			
ANTECEDENT CAUSE (S)		1 hour	
(B) <u>left cardiac decompensation</u>			
DUE TO			
(C) <u>dead on arrival.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at 2:30 A M, from the causes and on the date stated above.

SIGNATURE <u>Houace Deringer Joyce</u>		M. D. <u>Worton, Md</u>		DATE SIGNED <u>8/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>AUG. 25, 1955</u>		<u>FOUNTAIN CEMETERY</u>	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>WORTON (R.F.D) MD.</u>		<u>8/24/55</u>		<u>E. Kennard Jones</u>	
24. FUNERAL DIRECTOR		ADDRESS			
<u>B. R. FELLOWS</u>		<u>STILL POND, MD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 26 1955

RECEIVED